

**Community Mental Health Affiliation
of Mid-Michigan**

PROCEDURE #: 3.1	Page 1 of 3	SUBJECT: Recipient/Enrollee Rights
Related Policy(ies) #: 3.0		SUBJECT: Enrollee Rights
Issuing Director: Director of Affiliation Operations		Original Effective Date: 03/10/09

REVISED DATE

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Review Date(s)

06/21/10					
10/27/11					

I. PURPOSE:

To ensure that Medicaid Beneficiaries receiving mental health and substance abuse services have the rights and protections afforded through the Balanced Budget Act of 1997 (BBA) and the Michigan Mental Health Code (MHC).

II. STANDARDS:

- 42 CFR 438.100: Enrollee Rights
- 42 CFR 438.10
- PIHP contract 6.3.3
- LEP Policy Guidance
- Michigan Mental Health of 1974 as amended: Chapters 7 and 7A: Recipient Rights

III. DEFINITION(S): (if applicable)

IV. PROCEDURES:

- A. Services will be provided to enrollees in a manner and format that respects the rights and protections afforded them in the BBA and Michigan Mental Health code and are easily understood. This includes:
 - 1. Informational and instructional materials that are written at a 4th grade reading level or other media that:
 - a. Describe the availability of covered services and supports and how to access them;
 - b. Information on medication and diagnoses. (Some technical information such as prescribed medication and diagnoses may not meet the reading level criteria).
 - 2. Notification that written information is available in the prevalent, non-English languages spoken in the service area and in alternative formats and manner for persons with special needs such as those who are visually impaired or have limited reading proficiency. Information is provided on how to access those alternative formats.
 - 3. Notification that oral interpretation services are available free-of-charge for enrollees and potential enrollees for all non-English languages.
- B. General information is available to enrollees at intake or a reasonable time after enrollment. This includes:
 - 1. Any restrictions on the enrollee's freedom of choice among network providers.
 - 2. Grievance, appeal, and fair hearing procedures and timeframes that include:
 - a. The right to a fair hearing;

- b. The method for obtaining a hearing;
 - c. The rules that govern representation at the hearing;
 - d. The right to file grievances and appeals;
 - e. The requirements and timeframes for filing a grievance or appeal;
 - f. The availability of assistance in the filing process
 - g. The toll free numbers that the beneficiary can use to file a grievance or an appeal by phone;
 - h. The fact that when requested by the beneficiary, benefits will continue if the beneficiary files an appeal or a request for a fair hearing within the timeframes specified.
 - i. The beneficiary may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the beneficiary.
 - j. Any appeal rights that the state chooses to make available to providers to challenge the failure to cover a service.
3. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
 4. Receiving information on how to obtain benefits including authorization requirements.
 5. How to obtain benefits from out-of-network providers.
 6. Being informed about any restrictions on right to choose a network provider.
 7. The extent to which, and how, after-hours and emergency coverage is provided, including:
 - a. What constitutes emergency medical condition, emergency services, and post-stabilization services;
 - b. The fact that prior authorization is not required for emergency services;
 - c. The process and procedures for obtaining emergency services, including use of the 911 telephone system;
 - d. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the Medicaid contract; and
 - e. The fact that, subject to these provisions, the enrollee has the right to use any hospital or other settings for emergency care.
 8. Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care physician.
 9. Any cost-sharing requirements.
 10. How and where to access benefits that are available under the state health plan but are not covered under the PIHP contract. This includes cost sharing and transportation.
 11. Provision of information on advance directives procedures and applicable state law. Enrollees will be notified of any changes in state law as soon as possible but not later than 90 days after the effective date of the change.
 12. Information is available upon request on the structure and operation of the PIHP.
 13. That the PIHP and its network providers do not utilize physician incentive plans.
 14. The PIHP/designee will make a good-faith effort to provide written notice to enrollees of the termination of a contracted provider that provided regular care to them. The written notice shall be provided within 15 days after receipt or issuance of the termination notice.
 15. The PIHP/designee gives each enrollee written notice of any significant change, as defined by the state, in any of the general information.
- C. Right to request and obtain information:
1. All enrollees will be notified of their right to request and receive information on enrollee rights and protections at least once a year.
 2. Information provided will include all information listed in section B, 1-14 above.
- D. Enrollees have the right to:
1. Be treated with respect and with consideration for their dignity and privacy as confirmed in CMHSP/CA Rights policies and procedures

2. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
3. Receive information about available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

E. Provider-Enrollee Communication

1. Health care professionals acting within their scope of practice may advise or advocate on behalf of an enrollee who is their patient, for the following:
 - a. Health status, medical care or treatment options including any alternative treatment that may be self-administered.
 - b. Information needed to decide among relevant treatment options.
 - c. Risks, benefits, and consequences of treatment or non treatment.
 - d. Right to participate in decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

F. Services not covered on moral/religious basis

1. A PIHP electing not to provide, reimburse for, or provide coverage of a counseling or referral service based on objections to the service on moral or religious grounds must furnish information about the services it does cover as follows:
 - a. To the State when applying for a Medicaid contract or when a policy is adopted.
 - b. To potential enrollees before and during enrollment.
 - c. To enrollees within 90 days after adopting the policy with respect to any particular service, with the overriding rule to furnish the information at least 30 days before the effective date of the policy.

G. Right to participate:

The enrollee has the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

V. APPLICATION:

All CMHAMM CMHSPs/CAs and network service providers.

VI. MONITOR AND REVIEW:

The Director of Quality, Customer Service and Recipient Rights shall monitor CMHSP/CA compliance with these functions. The PIHP Director of Affiliation Operations will review this procedure annually. External review will include MDCH and CMS site visits and reporting.

VII. RELATED POLICIES AND PROCEDURES:

CMHAMM Policy 3.0 Recipient/Enrollee Rights